



**Cash-based Interventions for Health
programmes in Refugee Settings**
A REVIEW

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INTRODUCTION

The protection of refugees is firmly embedded in an understanding that human rights underpin all aspects of UNHCR's international protection work and provide the basic normative framework governing UNHCR's protection and assistance activities including in Public Health. In its efforts to assure that refugees are able to fully exercise their fundamental human rights and freedoms, UNHCR promotes the full implementation by States of their obligations under international refugee and human rights law as provided for, inter alia, in the 1951 Convention relating to the Status of Refugees, the International Covenant on Civil and Political Rights, and the International Covenant on Economic, Cultural and Social Rights¹.

UNHCR aims to enable refugees to maximise their health status by supporting them to have equal access to quality primary, emergency and referral health services as nationals. The different settings of UNHCR's operation, however, pose challenges due to the wide variety of healthcare systems, healthcare financing models and disease patterns and burdens, in each region, country and even sub-nationally within a country.

Since the early 1990s, social protection programmes, often focused on safe motherhood, have demonstrated that financial incentives can stimulate positive health outcomes in development settings. There is little documented evidence of the use of cash-based interventions (CBIs) for health services in the humanitarian context, except to provide access to health-related products (such as insecticide-treated bed nets) or to support nutrition.

The objectives of this review are to explore the following:

1. What does the literature say about the use of cash and vouchers to achieve health outcomes?
2. What are the lessons learned and how can these be applicable for UNHCR's public health programmes?

Section one reviews relevant experience from development settings. Section two presents case studies using CBIs for health in refugee settings, and consolidates these experiences to extract elements of good practice. Finally, section three draws conclusions and makes some careful recommendations for CBI for health programme design and implementation by UNHCR.

¹ Committee on Economic, Social and Cultural Rights, General Comment No. 14 (2000) on the right to the highest attainable standard of health (Article 12 of the International Covenant on Economic, Social and Cultural Rights). <http://www1.umn.edu/humanrts/gencomm/escgencom14.htm>

METHODOLOGY

This report has relied on desk-based research, through a review of secondary data. The literature included in this review was obtained via web searches, discussions via the Cash Learning Partnership (CaLP) D-Group forum² and email correspondence. Interviews with key informants, including health programme practitioners and researchers were also conducted. Although the review is mainly based on published material, it also includes grey literature and verbal reports.

² The CaLP D-group is an online forum for discussing and sharing information on cash-based interventions in emergencies.

I. CASH-BASED INTERVENTIONS AND HEALTH: AN OVERVIEW OF THE STATE OF EVIDENCE

I.1. BARRIERS TO ACCESSING HEALTH SERVICES AND RESULTS-BASED FINANCING

Although the quality of health services is an essential condition for the success of any health action, underutilisation of health services is more often influenced by demand-side barriers than supply-side limitations. These barriers which are linked to socio-economic, cultural and contextual issues are presented below showing that overall, there is a complex web of factors that stand in the way of achieving positive health outcomes. But, as Gaarder *et al* (2010: 8) summarise, “the extent to which the desire to invest in one’s health is reflected in the demand for healthcare depends on whether an individual identifies illness and is willing and able to seek appropriate healthcare.”

Historically, health interventions have focused on providing solutions to the supply-side of healthcare. A gradual shift in thinking increasingly linking financial payments and other incentives to health results has led to the emergence of “results-based financing” (RBF) as an alternative financing model for healthcare. RBF³ can be described as a “cash payment or non-monetary transfer made to a national or sub-national government, manager, provider, payer or consumer of health services after predefined results have been attained and verified” (Gorter *et al*, 2013: 13).

Although a broad range of RBF options⁴ can be identified, this paper will focus on cash transfers and vouchers as they are also the most common forms of financial incentives/cash-based interventions used in humanitarian settings.

Table 1: Demand-side barriers to accessing healthcare

Generic	<p><i>Costs:</i> direct, indirect and opportunity costs;</p> <p><i>Preferences and attitudes:</i> strongly linked to prevailing cultural norms (socio-cultural context), but shaped by the particular background and beliefs of each household member;</p> <p><i>Knowledge and information:</i> regarding the long-term benefits of accessing health and education services, regarding the options available (different facilities, which is best, etc.), and how to negotiate access to them (overcome the bureaucracy, etc.).</p>
Household endowments	Financial assets (income and wealth), human assets (especially the education level of decision-makers), social assets (networks, etc.), natural assets (ownership, use, and disposal of land) and physical assets (entitlement to, use, and ownership of productive and non-productive assets).
The societal context	The socio-cultural, political and market context.

Source: Witter *et al* (2015: 17)

3 The terms output-based approach (OBA) or pay-for-performance (P4P) are commonly used interchangeably with RBF.

4 These options can include both supply- and demand side interventions, described in more details in Appendix 1.

I.2.CONDITIONAL CASH TRANSFERS AND VOUCHERS

I.2.a. Definitions

Cash transfers are financial resource transfers to the most vulnerable. If a condition for use⁵ is applied or adherence to a given behaviour is specified, they are termed conditional, otherwise they are unconditional. In the specific context of health, conditional cash transfers (CCTs) can further be described, in line with the RBF thinking, as “demand-side payments for performance, where performance is healthy behaviour” (Glassman *et al*, 2009: 90).

Vouchers, on the other hand, are an entitlement that can be exchanged for subsidised goods or specific services. Here, supply-side effects are strong as the behaviours of both provider and consumer are directly influenced by the incentive (Grainger *et al*, 2014: 15). Oftentimes, vouchers are designed in situations of market and government failure to provide health services to specified population groups. Vouchers have also been presented as “one of the few instruments that allows health planners any degree of certainty that their subsidies are reaching the intended population groups” (Boler & Harris, 2010:8).

I.2.b. Design features

CCTs for health have been integrated into national social protection programmes since the early 1990s, initially in Latin America (WHO, 2008: 1). In this development context, CCTs have been designed to meet two main objectives:

- a. To provide a safety net to increase the consumption of the extreme poor (alleviating short-term poverty) and,
- b. To increase the human capital investment of poor households (alleviating long-term poverty).

Payments are usually made to women as part of programmes which verify compliance with conditions, and in which the amounts transferred are generally set to cover average consumption just above the poverty-level. Increasingly implemented across the globe, CCT programmes are now regarded as successful social protection strategies (Glassman *et al*, 2013: 1).

Research by Akresh *et al* (2012)⁶ concluded that CCTs significantly increase the number of preventative health services visits, while unconditional cash transfers (UCTs) do not appear to have such an impact, which lends to believe that conditionality has positive outcomes. A more recent systematic review conducted by Murray *et al* (2015: 10) exposed that there is in fact very little research evidence of the true use of UCTs for health. They continue to describe that cash transfer programmes (in the form of maternity benefits or allowances) have been

5 Conditionality is also at times defined as a requirement for *participation* in a programme, here is it understood as requirement for *use*.

6 A two-year pilot programme randomly distributed both conditional and unconditional cash transfers. Whereas conditional cash transfer schemes required families to seek quarterly child growth monitoring at local health clinics for all children under five years old, there was not such a requirement under the unconditional programmes.

implemented without specifically imposing conditions on targeted women for the uptake of specific goods or services. Instead, these programmes were assumed to facilitate access to health services by reducing financial barriers because of the context in which the transfers were made (including timing, e.g. during pregnancy). Glassman *et al* (2009: 93) further argue, citing examples from the education sector that “the mere suggestion” of conditionality can suffice to induce the desired behaviour. In some places, this has been termed “implicit” or “indirect conditioning” (Witter *et al*, 2015: 24). This is particularly noteworthy, given the increased use of cash transfers – often unconditional – in the humanitarian context and the proven lower cost of UCTs compared to CCTs.

This thinking is in sharp contrast with the design of voucher programmes which has the enforcement of conditionality at its heart. Typically, a voucher management agency, having received funding to implement the programme, provides vouchers to distributors. The target population, identified through a rigorous process, is then approached through community sensitisation visits or other marketing events. Once clients have a good understanding of the service offered, they receive the voucher from the distributor and may redeem it at the health facility of their choice for the service specified. Once the provider has offered the required service, they submit a claim to the management agency for reimbursement. The type and form of reimbursement depends on the programme (e.g. claims for equipment, service/treatment provided, etc.). Once the claims have been processed, the voucher management agency then reports back to the donor with clear and de-

tailed results about the scheme (Boler & Harris, 2010: 9).

I.2.c. Success factors

Unambiguous evidence shows that CCTs increase the utilisation of health services. Whether this directly translates into improved health status is a function of the quality of the health services that target recipients can access (Gaarder *et al*, 2010).

Unsurprisingly, CCTs are most relevant when the barriers to health access are cost-related. They have been particularly successful when integrated into a comprehensive programme that addresses all barriers to health access including supply-side concerns.

In general terms, the amount of the cash transfer, the design and enforcement of the conditions, the duration and sustainability of the programme, the efficiency of targeting and the transparency of programme administration are all factors that contribute to the success of CCTs (WHO, 2008: 3).

Vouchers are also a promising and increasingly used approach to target subsidies to individuals who, in the absence of the subsidy, were unlikely to have sought care (Grainger *et al*, 2014: 15). A number of specific design elements of voucher programmes have been shown to strongly impact their success such as using serial numbers to facilitate claim processing and monitoring, carrying out door-to-door voucher distribution which has proven to be especially effective in rural areas and implementing interventions that are priority services defined by the

Ministry of Health and currently underutilised by the most vulnerable. Whilst the vast majority of voucher programmes (70%) provide access to just one service, evidence suggests that when designed as a package of services, these programmes can be even more successful⁷.

It is worth stressing that due to their inherent conditionality, voucher programmes have been credited with stimulating competition amongst healthcare providers at worst and indirectly contributing to maintaining the health system by guaranteeing an income flow to health facilities at best⁸.

1.2.d. Limitations

Not every health intervention lends itself well to the use of cash transfers and vouchers. Both vouchers and CCTs have clear limitations outside the scope of preventive health. Curative health services for instance are unsuitably addressed through these RBF approaches as they are required when people fall ill, rather than on a regular, recurring basis. However, for some specific groups who require predictable recurring medical treatment, CCTs could provide a way to improve compliance and access to the treatment, e.g. observing anti-retroviral treatment regimes by HIV patients, or regular visits to sexually-transmitted illness (STI) clinics by sex workers (WHO, 2008: 1). Acute cases cannot be addressed through vouchers because of the time patients need to learn of and understand the scheme, receive and use the voucher. Similarly, accidents or other sudden conditions,

such as gender-based violence (GBV), are not ideally suited to vouchers nor CCTs⁹.

Another limitation relates to the “sustainability of the behaviour change desired” in terms of whether improved behaviour can continue beyond the CCT and voucher programme and for how long (Glassman *et al*, 2013: 12). This is largely determined by whether the initial reasons for not seeking health services persist. This is why many CCT have been designed with accompanying measures such as educational talks on nutrition, health and hygiene etc. to entice behaviour change for a better identification of the need for healthcare, to challenge issues/beliefs that could lead to unwillingness to seek healthcare and to foster positive coping strategies to develop stronger ability to seek healthcare.

1.3. LESSONS LEARNED

Although CCTs have been shown to improve health status, there is limited evidence on exactly which feature of CCT programmes matters most – the cash, the conditions or the social marketing of the programme (Samuels & Jones, 2011: 4). However, it is undeniable that for CCTs to be most successful, the poorest households must reach a minimum threshold of food consumption before they are able to make other investments in their well-being (Glassman *et al*, 2009: 113). Indeed, when there is too much competition on financial resources to meet basic needs, CCTs are more likely to be diverted for immediate consumption and not invested in the areas desired by the programme.

⁷ Interview with Dr. Anna Gorter (Independent) on 23 Sept 2015

⁸ Interview with Antonia Dingle (Marie Stopes) on 02 Sept 2015

⁹ Interview with Dr. Anna Gorter (Independent) on 23 Sept 2015

Lagarde *et al* (2009: 36-37) summarise well that the success of CCTs is “dependent on the magnitude of the barriers to accessing services”. On the demand side, financial considerations are key concerns. “Similarly, if the obstacles to healthcare utilisation by the population are on the supply side (lack of drugs, low density of facilities), CCTs will be less effective. In fact, the quality and availability of health services is probably a pre-requisite to the success of CCTs. There is ample evidence in the health services literature of households avoiding health services because of their poor quality. It is likely that even financial incentives would not be sufficient (nor necessarily recommended) to encourage the use of poor quality services”.

Existing good practice also suggests that careful consideration needs to be paid to the form conditionality should take – if any – and what additional support structures and complementary services need to be in place for cash transfers to improve health outcomes in particular, and human well-being more generally. In this respect, it is also important to investigate the impact of the programme on health providers as well as the ways in which government and aid agency programmes try to influence health behaviours (Glassman *et al*, 2009: 116). Given the holistic nature of health, impact in one area can benefit many others.

Vouchers have only proven successful when they address common conditions for which there are clearly definable health services with a start and an end to limit payment to clear conditions (Grainger *et al*, 2014: 15). This is why they have achieved such success in the field of maternal health.

Furthermore, a continuum seems to exist with vouchers providing access to one service on one hand and social health insurance on the other. As such, when the design of vouchers becomes more complex and introduces more services, they move further along this continuum¹⁰. It can thus be argued that the design of voucher programmes can provide a fertile ground for piloting localised insurance products.

10 Ibid

II. CASH-BASED INTERVENTIONS FOR HEALTH IN REFUGEE SETTINGS: AN EMERGING PRACTICE

In the humanitarian context, CBIs are “the provision of money [or vouchers] to individuals or households, either as emergency relief intended to meet their basic needs for food and non-food items, or services, or to [access] assets essential for the recovery of their livelihoods.” (DG ECHO, 2013: 3). With this statement of objective focussed on short-term consumption smoothing, there is a departure from the RBF approach which frames the use of CCTs and vouchers as also contributing to alleviating long-term poverty¹¹. Furthermore, in CBIs for health in humanitarian response there are less resources (time and financial) allocated to affecting the behaviour of target beneficiaries in a way that impacts human capital outcomes. Berg & Seferis (2015: 10) also caution not to equate CBIs with social protection strategies. As such, CBIs for health should be defined as short-term resource transfers to offset the costs of accessing health services. However, it is not to say that CBIs for health in humanitarian response do not have long-term health and well-being effects by preventing disaster-related health shocks (such as for instance psychological trauma) which may otherwise develop into a chronic condition (such as clinical depression), (Pega *et al* (2015). What is more, any health investment has important external benefits¹².

11 See section I. 2. B.

12 Much literature documents for example the impact that deworming children has on increasing school attendance.

Pega *et al* (2015)'s Cochrane review¹³ found that evidence of humanitarian programmes specifically designed to use CBIs for health outcomes is very limited. However, many evaluations of cash transfer programmes providing qualitative information on the use of cash tend to suggest that a certain proportion of the amount transferred is spent on medicine and health services¹⁴.

II.1. EXPERIENCE FROM UNHCR

Recognising that access to health services is conditioned by physical, social, cultural and economic concerns, UNHCR aims to enable refugees to maximise their health status by supporting them in having similar access to quality primary, reproductive health and emergency and referral health services as nationals (UNHCR, 2014). Meeting these objectives can be challenging in urban and out camp situations, where refugees may face obstacles in accessing health services.

13 Cochrane Reviews aim to comprehensively synthesise the existing body of evidence on the effectiveness of interventions in improving health service use and health outcomes. They are considered the highest level of evidence in medicine and public health.

14 This can only be anecdotally estimated as an average of self-reported expenditures in a given unconditional cash transfers programme. This is highly context and timing dependent and likely concerns curative health. Interview with Sarah Bailey (ODI) on 23 Sept 2015.

II.1.1. Limitations

UNHCR supports refugees to access comprehensive reproductive health care as soon as the situation stabilises (UNHCR, 2014). Within its response to the Syrian refugee crisis, as part of an integrated package of services, UNHCR has, thus, been providing short-term cash payments to offset costs of accessing maternity services in Egypt and will soon do the same in Jordan. Syrians generally have high demand for healthcare services. However, in both these countries, the majority of refugees live in urban areas (outside of camps). With rent alone often making up over 70% of their overall expenditure, this places pressure on already limited income and reduces the ability to consistently meet basic needs.

In Egypt, UNHCR has shifted from a strategy that directly reimbursed health facilities for providing maternal care to pregnant Syrian refugee women to a programme where these pregnant women directly receive the cash equivalent of the same maternal services with the objective that they use it to pay for maternal cost in particular facility-based delivery. The agency is planning to initiate a similar scheme in Jordan.

Both Egypt and Jordan display similar characteristics that make possible the use of CCTs for maternal health:

- a. Syrian refugees are legally entitled to use public hospitals at a subsidised rate.
- b. There is a network of public hospitals catering to the needs of the national population at an acceptable level of quality.
- c. In addition, this network is wide enough

to accommodate the large geographical spread of the refugee population.

- d. Syrians traditionally have a strong demand for health services.
- e. CBIs for health are implemented in a context of existing CBI programmes in these countries.

Initiated with the objective to control costs, as Syrian refugees can access public hospitals for a nominal fee, the CBI for reproductive health programme has shown promising results in Egypt where it has been implemented since 2015 with no significant decrease in health outcomes compared to the previous system based on reimbursement.

The table below provides a summarised overview of the cash transfer for maternal health programmes designed by UNHCR in Egypt and Jordan for the benefit of Syrian¹⁵ refugees.

15 UNHCR provides support to other refugee populations such as Iraqis, Somalis, etc. but only Syrians are presented here for easier comparison making.

Table 2: UNHCR CBI for health synopsis

	Egypt	Jordan
Refuge context	<ul style="list-style-type: none"> ▪ 56,000 Syrians refugees plus 133,000 Syrians under temporary protection¹ ▪ 100% of Syrian refugees live outsidess of camps 	<ul style="list-style-type: none"> ▪ 628,175 Syrians refugees² ▪ Over 83% of Syrian refugees live outsidess of camps
National health access policy for Syrian refugees	Syrian refugees are granted access to Egyptian primary public health by national decree for a nominal fee	As of Nov 2014, Syrian refugees are no longer granted free access to the Jordanian public health system. Instead they are required to pay non-insured Jordanian rates
Programme start date	January 2015	December 2015
Programme scale	2,000 pregnant women/year	TBD
Targeting criteria	Pregnancy	Pregnancy Income vulnerability (being an existing recipient of the UNCHR cash assistance programme or meet other vulnerability criteria) or high risk pregnancy
Conditionality	Attendance of a minimum of one medical check-up (two for full assistance)	Attendance of a minimum of one medical check-up
Programme description	A pregnant refugee woman makes a visit to UNHCR’s partner health services provider (Refugee Egypt)’s clinic for a medical check-up, registration of the pregnancy, counselling and referral to public hospital for child delivery. On this first visit, following confirmation of the pregnancy, Refugee Egypt will give the woman half the amount of her entitlement and the other half during another medical visit after child delivery, rest upon presentation of the birth certificate.	A pregnant refugee woman/girl or her caregiver presents themselves to UNHCR’s partner health services provider (JHAS)’s clinic to request assistance. Patient eligibility into the programme is checked, key counselling messages are delivered and Once eligibility is confirmed, cash is transferred within 72 hours to allow for antenatal visits and again at 36 weeks of pregnancy in time for the planned delivery.
Transfer details	Cash-in-hand	Via bank teller (with the objective of transitioning to iris scan technology-when ATMs will be used)
Amount paid	2 Antenatal visits provided free of charge by Refugee Egypt + 300 EGP (38 USD) (normal delivery) 600 EGP (76 USD) (C-section . Need may be confirmed by Refugee Egypt during the second ANC visit or by the doctor at the time of delivery)	Antenatal visits: if pregnancy is registered during 1 st trimester (40 JD), 2 nd trimester (25 JD), or 3 rd trimester (15 JD) + 60 JOD (85 USD)(normal delivery) 300 JOD (425USD) (C-section following confirmation of need by JHAS)

Table 2: UNHCR CBI for health synopsis (cont.)

Cost of child delivery at a public facility	Officially free of charge but the cost of safe motherhood kits patients are required to provide: 300 EGP (38 USD)(normal delivery) 600 EGP (76 USD) (C-section)	50-60 JOD (70-80 USD)(normal delivery) 180-200 JOD (300 – 420 USD) (C-section)
Cost of child delivery at a private facility	1,500 EGP(190 USD) (normal delivery) 4,000 EGP (500 USD)(C-section)	140-220 JOD (200-300 USD) (normal delivery) 250-300 JOD (560-700USD) (C-section)
Complementary services provided	<ul style="list-style-type: none"> ▪ Free coverage of birth related complications (if delivery at a public facility) ▪ Support for high risk pregnancies ▪ Community health volunteers at the public clinics will facilitate and ensure the availability of counselling on Family Planning, promotion of exclusive breastfeeding, etc... 	<ul style="list-style-type: none"> ▪ Free coverage of birth related complications (if delivery at a public facility) and secondary healthcare needs
Cost-efficiency considerations	<ul style="list-style-type: none"> ▪ Since refugees are able to access health services at subsidised rate, this thus makes less demand on budget than the direct provision health services, which is at full cost 	<ul style="list-style-type: none"> ▪ Payment of health costs by refugees at public hospitals is at the non-insured Jordanian rate which is highly subsidised; if UNHCR through their partner JHAS refers the patient as under the current system they are charged the foreigners' rate which is typically 35 – 60 % higher
Monitoring	<ul style="list-style-type: none"> ▪ Periodic programme-wide satisfaction survey 	<ul style="list-style-type: none"> ▪ During initial pilot all beneficiaries will be telephoned to assess the process (identification, counselling, receipt of cash) and if cash was used for intended purpose ▪ Telephone survey of random sample of beneficiaries using a standard questionnaire
Challenges	<ul style="list-style-type: none"> ▪ Poor perception of quality of services at the public health facilities leading to a preference for child delivery at a private hospital where rates of C-section tend to be higher and assistance provided covering at best 20% of the cost ▪ Decreasing number of reported pregnancies 	<ul style="list-style-type: none"> ▪ Too early to report but concern that due to reduction in WFP food voucher support, programme participants may reduce attending antenatal visits to save part of the assistance for other uses

Source: Interviews with Hany Fares (UNHCR) on 24 Aug 2015, Dr. Ann Burton (UNHCR) on 02 Sept 2015, Mamoun Abuarqub (UNHCR) on 07 Oct 2015, Ibraheem Abu-Siam (UNHCR) on 14 Oct 2015 and UNHCR 2015a, 2015b, 2015c, 2015d.

1 UNHCR (2015d)

2 UNHCR Data Portal accessed on 11 Oct 2015 (<http://data.unhcr.org/syrianrefugees/regional.php>)

II.1.2. Health insurance and cash

Whilst CBIs for health is an emerging area of practice for UNHCR, UNHCR has developed extensive experience in enabling refugees to access national health insurance and to enrol in voluntary health insurance schemes. To ensure the payment of premiums, different options are being used:

- a. Refugees contribute themselves directly,
- b. UNHCR pays directly the health insurance scheme for the most vulnerable or,
- c. UNHCR provides multi-purpose cash to socio-economic vulnerable refugees to ensure that they can pay the premium.

In Ghana, in collaboration with the Ministry of Health, UNHCR designed a three-year plan to enrol refugees into the national health insurance programme. The Ghanaian authorities welcomed the full integration of refugees into the national health services through the use of the National Health Insurance Scheme's (NHIS) biometric database. After enrolling into the biometric database, refugees can access health facilities and receive health services in the same way as any NHIS cardholder and Ghanaian national.

In parallel, UNHCR invested in healthcare facilities within refugee camps in Ghana to bring them up to full capacity standards to offer quality care for refugees and national populations alike. The health facilities were then handed over to service providers registered with the NHIS, the Ghana Health Service and the National Catholic Secretariat, to receive reimbursement for the services delivered. UNHCR initially

paid the first two years of NHIS enrolment as well as for newly arrived refugees. After 3 years, most refugees are expected to have developed the economic means to continue to pay for the services. The most socio-economic vulnerable refugees, however, are planned to be provided with multipurpose cash grants to help them cover future insurance premium costs. Since health insurance is mandatory in Ghana, it is imperative that refugees are fully aware of the need to pay the premium to maintain their access to health services.

II.2. GOOD PRACTICE

Combining the limited experience on the use of in CBI for health in refugee situations and the longer-standing evidence from the development sector, some elements of good practice can be inferred and contextualised for the use of CBI for health in refugee settings.

1. **Understanding the health system:** A thorough understanding of the existing health system, the challenges and barriers to access health services is required.
2. **Targeting the type of health service:** Not all health services lend themselves to the use of CBIs. Health services for which a predictable package of services can be identified, such as in the case of reproductive health, or persons with chronic diseases, may be the most suited areas of interventions.

3. Setting the appropriate amount: A key priority is to set the amount of assistance at a level that is high enough to provide a fair incentive for the target group to fulfil the condition (World Bank, 2008: 3) as it is essential that the poorest households reach a minimum threshold of food consumption and other basic needs before they are able to make other investments in their well-being (Glassman *et al* 2009: 115).

In general terms, assistance has been calculated to cover costs for antenatal, delivery and postnatal visits, for medication (if not provided free of charge), transport, food, accommodation for people accompanying the women as well as the opportunity costs for the women of giving birth, e.g. the time lost on livelihood related activities¹⁶. In addition it has been proven efficient to deliver the cash assistance at the health facility where antenatal visits are conducted (Samuels & Jones, 2011: 4).

In long-term programmes like *Bolsa Familia*, the amount transferred is proportional to the economic poverty of the family (Rasella, 2013). Some of the programmes with the largest impact on health and education in Latin America (such as *Bono de Desarrollo Humano* (BDH) in Ecuador and *Chile Solidario*) were the ones with the smallest transfer size (Witter *et al*, 2015: 25). Whilst this may not be appropriate for

most aid agencies, it is interesting to note that in some programmes, women who made all the antenatal visits and delivered at a health facility were offered a “bonus” payment set at 20% of the poverty line monthly mean income over a period of six months (Samuels & Jones, 2011: 4).

4. Quality of supply (service): Recognising that perception of poor service quality is a major barrier to seeking health services, supply-side interventions to deal with potential problems such as low service quality, staff shortage or medical supply bottlenecks, are the first prerequisite for a successful CCT (World Bank, 2008: 3).

5. Conditionality: The extent to which conditionality should be applied is not resolved in the literature. However, it is important to ensure that verification of the use of the cash transfer is applied as part of the monitoring activities of the programme.

UNHCR CBIs for health rely on “implicit conditionality”¹⁷, which can be sufficient for refugees who already have high demand for health services. Since the quality of the protection environment in the country of asylum has an impact on conditionality and the form it should take, including accompanying measures, it will continue to dictate what additional support this and other refugee populations may require in the future.

¹⁶ Additional healthcare costs not covered by a programme, and fear of these costs, can still be prohibitive for the poor including those resulting from geographical remoteness and poor transport links. Similarly, social barriers such as women’s household responsibilities can still delay uptake or cause early self-discharge from hospital, and need to be addressed with wider social interventions (Murray *et al*, 2015: 9).

¹⁷ See section 1.2. b.

- 6. Monitoring:** Good practice does not just constrain monitoring activities to programme process verification, but also includes follow ups in the referral pathway for care. Programmes should thus be designed with enough flexibility to quickly realign processes with objectives.

A rigorous monitoring process should be designed and a case management approach should be used. The objective is to ascertain not only that entitled beneficiaries received their cash transfer, spent it on quality health services but also that the cash received did not disrupt household cohesion. In addition, a complaints mechanism should be put in place to support the beneficiary and single out facilities that provide substandard quality of care.

- 7. Integrated programming:** Increasingly, the evidence suggests that the best results are achieved when maternal health interventions are highly contextualised and integrated in a suite of services and complementary programmes (Jones *et al*, 2011: 1). This is consistent with UNHCR's policy to integrate healthcare for refugees into national public health, including through insurance schemes as evidenced in Ghana. Voucher programmes relying on social franchise models have also been designed to successfully address shortcomings in public health offerings.
- 8. Participation:** Designing programmes in collaboration with their future intended beneficiaries has been effective in addressing the actual barriers leading to un-

derutilisation of maternal health services. Furthermore, returning a sense of control and independence to local actors can help communities recover from a crisis (IWAG, 2010: 11). Overall stakeholder engagement with key actors of the health system including government entities is equally crucial.

Relying on community-based agents for behaviour change communication and other programme support activities had also shown good results, as experienced in Egypt to some extent. The degree of transparency and accountability of the programme should be the focus of detailed programme evaluation.

III. CONCLUSIONS AND RECOMMENDATIONS

The success of CBIs in support of refugee health programmes has been determined by the provision of adequate incentives on both the demand and supply sides, as part of a comprehensive programme that addresses economic, social and cultural determinants of healthcare access and provision. The current UNHCR experiences focusing on reproductive health, offers tremendous learning opportunities to test assumptions of suitability and the potential of cash for improving access and health outcomes.

In determining whether CBIs for health is a suitable programme design option for UNHCR, the range of feasibility assessments required for all CBIs should be applied including a market assessment to determine the presence and the geographical spread of health facilities, that may require CBIs to ensure the access to the services, the quality of the services available at health facilities; access conditions to these services; prices and payment conditions. Other considerations include the ability to identify and deliver cash or voucher to target refugees in a safe and secured manner, a security context that allow movements of refugees and supplies for timely access to and service provision of health services¹⁸.

Particular consideration should include the following:

- a. Universal access to health services** should be the starting point for any CBIs for health. The focus of UNHCR's health programmes is a combination of preventative and primary health care that employs a public health and community development approach with an emphasis on primary health care and support to access more advanced levels.
- b. Understanding the barriers and obstacles in accessing health services** is critical to determine if there are specific areas and services that would benefit from CBIs to improve the access to health care and the health outcomes.
- c. The health-seeking behaviours** of the target population. The lower the demand for health services among a target group the less effective CBIs are at achieving desired expenditure by recipients.
- d. Current levels of welfare.** The more challenges refugees face in meeting their basic needs such as food, shelter the higher the tension between meeting these and prioritising health needs are, which may lead to diversion of funds away from the expenditure desired by the pro-

18 For details, see UNHCR (2015) Operational Guidelines for Cash-Based Interventions in Displacement Settings.

gramme. On this basis, it is easily conceivable that the same programme targeted a refugee living in absolute poverty and another one in abject poverty may deliver different outcomes.

- e. Intra-household patterns of expenditure and who in the household is responsible for decision-making on health expenditure.** Low prioritisation of expenditure on women and children can negatively impact programme success. This understanding can help inform the complementary activities that need to be conducted as part of the CBIs.
- f. The cost-effectiveness of a CBIs.** The launch of CBIs for Health in Egypt and Jordan stem from the realisation that finding a way for refugees to pay for health services themselves can help reduce implementation costs for programmes targeting a group that traditionally has high demand for health services.

For all these reasons, CBI for health must be part of an integrated programme that endeavours to provide mitigating measures to the above-mentioned factors and others that may be identified during the assessment phase. In addition, targeting and eligibility criteria, monitoring, respectful treatment of beneficiaries, suitable incentives for providers, and the need for investment in quality of care and affordable referral systems are all areas needing detailed and context-specific attention (Murray et al, 2015: 11).

To guide programme planning, design and implementation, the following recommendations are made as minimum areas of focus.

III.1. RESPONSE ANALYSIS

- When conducting a feasibility assessment, as mentioned above, the appropriateness of a CBIs for health is influenced by:
 - a. Demand for health service amongst target population.
 - b. Ability of refugees to access quality¹⁹ healthcare services at lower cost than through UNHCR/partner direct implementation in the required localities.
 - c. Security and freedom of movement of refugees, staff and resources (including cash delivery mechanisms).
- What CBI methodology and conditionality is best suited to an intervention is dependent on the context as determined by the risk analysis as well as the cost and benefit analysis.

¹⁹ Quality indicators include: availability, accessibility, equity, appropriateness, acceptability, effectiveness and efficiency (see: UNHCR's Public Health Guiding Principles, p17). Lagarde *et al* (2009: 37) argue that "in fact, the quality and availability of health services is probably a pre-requisite to the success of CCTs".

III.2. PROGRAMME DESIGN AND IMPLEMENTATION

- When setting the cash transfer value, the full cost of health services for a given condition must be provided for. In the case of maternal health for instance, this includes ante-natal visits, delivery and post-natal visit with the flexibility to cater for complications²⁰. In addition, supporting transports costs and out-of-pocket expenses should be further explored to maximise protection outcomes directly through working with partners²¹.
- Arguably, the most effective way to enforce conditionality is to ensure that basic needs are met and there is no competition for resources at the household level. In addition to this, sensitisation and behaviour change communication are effective ways to direct expenditure towards the desired health costs. There should be no as to what the objective of the CBIs for health is.
- For successful implementation, any CBIs for health should be based on standard operating procedures (SOPs) with clear objectives, target population, inclusion criteria, and steps for the cash transfer, protection considerations, reconciliation, monitoring and evaluation. SOPs should be updated regularly.
- Evidence has shown that complementary programming should be actively promoted. This can be done by linking refugees with other UNCHR activities

such as women safe space or through referral to other organisations that may provide additional support.

- The time-sensitivity of the different types of health assistance should be considered. For instance, for CBIs for maternal health, pregnant refugee women should strongly be advised to visit the health centre at least once during the first trimester when the risks are higher. Proportional assistance for antenatal visits as provided by UNHCR Jordan is probably an example of good practice when child delivery is not free of charge. In addition, sustained cash assistance could be in place for a minimum guaranteed period following child birth²².

III.3. MONITORING AND EVALUATION

- A rigorous monitoring process should be designed capturing key health and CBI-related indicators as well as customer service experiences. As emphasised in the UNHCR's Public Health Guiding Principles, to monitor quality, functioning public health information systems must be in place and used and appropriate feedback provided.
- A complaints mechanism that is trusted by refugees should be put in place to support refugees and single out facilities that provide substandard quality of care.
- Lessons learned should constantly be fed back into programme design.

20 In social protection programmes, the value is set to coverage average consumption just above the poverty-level, to meet basic needs with a nominal margin.

21 For example, UNHCR Jordan has set up a referral pathway with INGO partners for supporting additional needs such as transportation and infant nutrition when breastfeeding is not an option.

22 In fact, Jones *et al* (2011: 2) argue that using the first antenatal visit as the qualifier, extending support to women until the child reaches 36 months is strongly advocated for an overall improvement of the health status of mother and child.

IV. TOOLS, GUIDANCE AND RECOMMENDED READING

Although the field of financial incentives for health and that of healthcare provision in emergencies are not new, their convergence is. Hence, there is little documented guidance which addresses both in a single document. The following list of sources has thus a strong focus on healthcare provision.

CBI GOOD PRACTICE REVIEWS AND GUIDANCE

- UNHCR (2015) *Operational Guidelines for Cash-Based Interventions in Displacement Settings*. Geneva: UNHCR
Available at: <http://www.refworld.org/docid/54d387d14.html>
- Harvey P. and S. Bailey (2011) *Cash Transfer Programming in Emergencies: Good Practice Review 11*. London: Humanitarian Practice Network, Overseas Development Institute.
Available at: <http://www.odihpn.org/download/gpr11.pdf>

POLICY RESEARCH

Conditional cash transfer programming

- Fiszbein, A. and N. Schady (2009) *Conditional Cash Transfers: Reducing Present and Future Poverty*. Washington, DC: The International Bank for Reconstruction and Development/World Bank.
Available at: <https://openknowledge.worldbank.org/bitstream/handle/10986/2597/476030PUB0Cond101Official0Use0Online1.pdf?sequence=1>

FRAMEWORKS

Conditional Cash Transfers Design and Evaluation

- Glassman, A., J. Todd, and M. Gaarder (2009) "Latin America: Cash Transfers to Support Better Household Decisions" in Eichler, R., R. Levine and the Performance-Based Incentives Working Group, *Performance Incentives for Global Health, Potential and Pitfalls*. Washington D.C.: Center for Global Development. Chapter 6, pp. 89-121
Available at: <http://www.cgdev.org/sites/default/files/9781933286297-Levine-performance-incentives.pdf>

Pp 117-118 Box: Designing and evaluating CCTs

UNHCR Health Programmes Monitoring and Evaluation

- [Twine.unhcr.org](http://twine.unhcr.org)

Voucher Programme Design and Evaluation

- Boler, T. and L. Harris (2010) *Reproductive Health Vouchers: from promise to practice*. London: Marie Stopes International. Available at: <https://mariestopes.org/sites/default/files/vouchers-from-promise-to-practice.pdf>

EVIDENCE REVIEW

RBF for Maternal Health in Development Settings

- Gorter A.C., P. Ir and B. Meessen (2013) *Evidence Review, Results-Based Financing of Maternal and Newborn HealthCare in Low- and Lower-middle-Income Countries*. A study commissioned and funded by the German Federal Ministry for Economic Cooperation and Development (BMZ) through the sector project PROFILE at GIZ – Deutsche Gesellschaft für Internationale Zusammenarbeit. Available at: <http://www.oecd.org/dac/peer-reviews/Evidence-RBF-maternal-health.pdf>

Cash transfers for nutrition

- Bailey, S. and K. Hedlund (2012) *The Impact of Cash Transfers on Nutrition In Emergency and Transitional Contexts: A Review of Evidence*. London: Overseas Development Institute. ISBN: 978-1-907288-62-3 Available at: <http://www.odi.org/sites/odi.org.uk/files/odi-assets/publications-opinion-files/7596.pdf>

SYSTEMATIC REVIEWS AND COCHRANE COLLABORATIONS

Unconditional cash transfers for health in humanitarian settings

- Pega F., S.Y. Liu SY, S. Walter, S.K. Lhachimi (2015) *Unconditional cash transfers for assistance in humanitarian disasters: effect on use of health services and health outcomes in low- and middle-income countries*. Cochrane Database of Systematic Reviews, Issue 9. Art. No.: CD011247. DOI: 10.1002/14651858.CD011247.pub2.

RBF for maternal health in development settings

- Murray, S. F., B. M. Hunter, R. Bisht, T., Ensor and D. Bick (2015) *Effects of Demand-Side Financing on Utilisation, Experiences and Outcomes of Maternity Care in Low- and Middle-income Countries: a Systematic Review*. BMC Pregnancy and Childbirth, 14:30 Available at: <http://www.biomedcentral.com/content/pdf/1471-2393-14-30.pdf>

- Glassman, A., D. Duran, and M. Koblinsky (2013) *Impact of Conditional Cash Transfers on Maternal and Newborn Health*. CGD Policy Paper 019. Washington DC: Center for Global Development.
Available at: <http://www.cgdev.org/sites/default/files/impact-conditional-cash-transfer-health.pdf>

Vouchers for maternal health in development settings

- Gorter, A. C., C. Grainger, J. Okal and B. Bellows (2012) *Systematic Review of Structural and Implementation Issues of Voucher Programs. Analysis of 40 Voucher Programs. In-depth Analysis of 20 Programs*. Nairobi, Kenya: Population Council.

V. REFERENCES

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Available at: <https://mariestopes.org/sites/default/files/vouchers-from-promise-to-practice.pdf>
- Browne, E. (2013) *Theories of Change for Cash Transfers* (GSDRC Helpdesk Research Report 913), Birmingham, UK: Governance and Social Development Resource Centre, University of Birmingham.
Available at: <http://www.gsdrc.org/docs/open/HOQ913.pdf>
- ECHO (2013) *The Use Of Cash And Vouchers In Humanitarian Crises – DG ECHO Funding Guidelines*. Brussels: ECHO
Available at: http://ec.europa.eu/echo/files/policies/sectoral/ECHO_Cash_Vouchers_Guidelines.pdf
- Gaarder, M., A. Glassman and J. Todd (2010) 'Conditional Cash Transfers and Health: Unpacking the Causal Chain'. *Journal of Development Effectiveness*, vol. 2, No. 1, March.
Available at <http://www.pegnet.ifw-kiel.de/members/gaarder.pdf>
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- Inter-agency Working Group (IAWG) on Reproductive Health in Crises (2010) *Inter-agency Field Manual on Reproductive Health in Humanitarian Settings*. Available at: http://iawg.net/resources/field_manual.html#download
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- Available at: <http://www.odi.org/sites/odi.org.uk/files/odi-assets/publications-opinion-files/7488.pdf>
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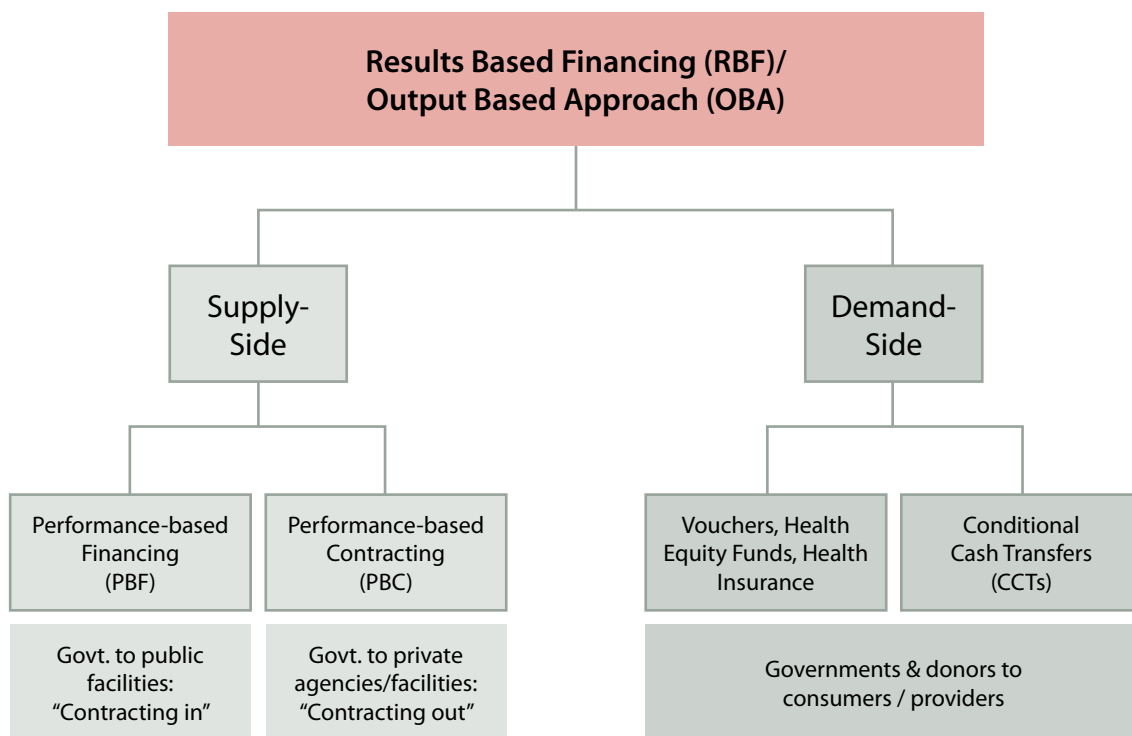
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APPENDIX 1 SUPPLY AND DEMAND-SIDE APPROACHES IN RBF



Source: Naimoli *et al* (2010), quoted in Gorter *et al* (2013: 1)

